# Children's Disability Services Workgroup

Meeting #4
October 22, 2012, 10:00 am – 3:00 pm
Polk County River Place
2309 Euclid Avenue
Des Moines, IA 50310

# MINUTES

**ATTENDANCE**

**Workgroup Members:** Jennifer Vermeer, Mark Peltan, Marilyn Althoff, Susan Walkup, Wendy Rickman, Gail Barber, Shanell Wagler, Nicole Beaman, Sheila Kobliska, Dana Cheek, David Stout, Jerry Foxhoven, Jason Smith, Jason Haglund, Debra Waldron, Samuel Kuperman, Jim Ernst, Marilyn Lance

**Legislative Representation**: Senator Nancy Boettger, Representative Dave Heaton

**Facilitator:** Elizabeth 'Liz' Waetzig, Change Matrix

**DHS/IME Staff:** Director Charles Palmer, Joanna Schroeder, Laura Larkin, Pam Alger, Jen Harbison, Theresa Armstrong, Sally Nadolsky

**Other Attendees:**

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| Kelley Pennington | Magellan |
| Kris Bell | SDC |
| Tony Leys | *Des Moines Register* |
| Susie Osby | PCHS |
| Nancy Becklev | Easter Seals |
| Aaron Todd | Legislative Services Agency (LSA) |
| Amber DeSmet | Legislative Services Agency (LSA) |
| Brice Oakley | Iowa Alliance of CMHC, Orchard Place |
| Kristie Oliver | Coalition for Family & Children Services |
| Rhonda (Boltz) Rairden | Iowa Department of Public Health (IDPH) |
| Vickie Miene | Community Circle of Care/ CHSC |
| Sandi Hurtado-Peters | DOM |
| Susan Whitty | INA |
| Judith Collins | INA/SOC |
| Sheila Hansen | CFPC |
| Maria Montanaro | Magellan |

## INTRODUCTORY COMMENTS

- The workgroup will need to get to specific recommendations in terms of implementing systems of care (SOC)/health homes.
- This is a legislatively generated group so it will report back to the governor and legislature.
- Don't think the issue of fragmentation will be solved today but I do think it needs to be addressed in the report. The group should make people aware of the dysfunction, but at the same time without undermining the great work going on.
- It's important to frame the conversation: the life of a child across the system. This workgroup has a sense of the system as you would like it to be.
- We're focusing on health homes for children/youth with a serious emotional disorder (SED) because they provide an opportunity to be developed now. From there, begin thinking about how these could build out to a bigger system.

## GOVERNANCE STRUCTURE POPULATION DISCUSSION

Conversation began with a review of what the workgroup had discussed during the last meeting (see minutes).

- How are you seeing children with intellectual disabilities (ID) in this conversation? The focus is for children/youth with SED unless he/she has a co-occurring diagnosis. We are approaching the goal of integrating target populations but we haven't figured out how to do it with the ID population. But what we learn from these models will be critical to building other models.
- Could this be identified in the report because I've been having conversations with legislators that children don't get lumped into the conversation? There are other parts related to redesign that does address the ID population including assessments, no wrong-door, Balancing Incentive Program (BIP), etc. and these need to be taken into consideration as well.
- I think the SOC model in Northeast Iowa has worked well but not sure if it would work across the state. However, I think there are elements of this that would be good for children/youth in other parts of redesign. As we build the system, please look at care coordination for children with ID.
- As we start looking at vulnerable populations needs it is important to remember the foster care population is something we may want to consider looking at for a next population. These children/youth can require high-end services and more attention focused on their needs.
- Need to build an oversight structure into the growth structure so we don't get stuck in one place – process improvement.
- There was an improvement partnership started in Vermont specifically devoted to children's issues and included public/private partnership. State/academics/local chapters and department of health come together around specific health issues (VCHIP). It is part of the NIPP national network. Consider potentially embedding this program within the state. Iowa has been receiving some technical assistance to develop a partnership.
- As we develop specialized health homes, quality measurement needs to be a part of the system. Need to build some tools into what the SOC would utilize.

## Recommendation of Population of Focus

- System of Care should initially focus on children/youth with SED whose needs are not met in primary health homes.
- The focus population should include children/youth who have complex needs and complex treatment needs. Some kind of combination of SED and functional impairment.
- Children/youth should have personal choice of providers.


## Governance Structure Partner Discussion

Conversation was kicked off with the question, What it is that you need from the State to get it going, to keep it going? An initial discussion took place during the last meeting (see minutes). Also refer to Iowa System for Children DRAFT Chart.

IME is planning to submit the SPA for specialized health homes soon with the goal of starting in April 2013. This will happen before the legislature actually acts on the recommendations of this group, but group's work is still important in implementation and development of the system.

- There are several pivotal questions: Who is it we're serving? How do we go about changing delivery to most regionalized treatment? How do you get services out to every place? How do we get the right services to the right people at the right time?
- Recommend adding community-based partners.
- There is a public piece but needs to be private piece, for example, Blue Cross Blue Shield.
- Recommend adding business and employer groups.
- Do we need a broader court representation than Juvenile Justice? Court involvement is more than just juvenile justice.
- I recommend that the Judicial Districts should be at top and Juvenile Justice should be in Tier 2.
- Don't think we can draw the line today. I recommend starting with Medicaid and build from there as a way to get it off the ground and create the entities that would do the work and expand over time.
- Recommend the group is fluid enough to be able to make recommendations down the road as to who should join the governance team.
- How does the case management system coordinate with the care coordination? It could be the Medicaid program in the beginning in terms of who is coordinating the system.

- How do we get Area Education Agencies (AEA) to buy in to the system / become players? It starts with the governor/legislatures than move to discussions with the Department of Education.
- I recommend that in the report we emphasize the importance of school and the need for AEA's to work with schools.
- Is there a role for colleges/universities to be at the table? Someone with an academic background for higher-eds. This may be the Board of Regents.
- What is the incentive to participate and how will it be offered?

Who is the lead of the Governing Structure?

- Recommend that IME serves as leader for now. Who the convener is in Year 1 can look very different than who the convener is in Year 5 as the system evolves.
- Recommend that participation along with expectations is mandatory and that participants are asked to participation through legislation.
- What kind of authority does the leader have or what type of the authority does the group have?
- Recommend the governing structure has the responsibility to:
    - Gather information and understand how it is working;
    - Resolve tensions and problem solve;
    - Keep the system moving to the next stage through process improvement methodology;
    - Fiscal responsibility to look at costs;
    - Responsible for ensuring services are evidence-based;
    - Provide guidelines around what services are being delivered;
    - Enforcement or accountability/performance on individual health homes: set expectations regarding quality, cost, growth, and outcomes;
    - Population management: both children and family are doing well but entire population is doing well; and
    - Set strategies that would decrease further involvement in higher level services, i.e. original goal is to bring kids back from out of state (OOS) and ensure they don't go OOS.
- I recommend there is a joint agreement on goals and this is done through a memorandum of understanding between agencies and those who serve as part of the governing structure.

## DRAFT CHARGE

> *This group will support and promote optimal, well-being/whole person/person centered*, cross-system long and short term outcomes for children and youth. Families, agencies, disciplines and others will convene to build and oversee implementation of a successful children's system that starts with quality, effective, specialized health homes and evolves to a comprehensive and coordinated statewide children's system.*

*There was no consensus on words in red. Further discussion needed.

## DISCUSSION ON DEVELOPMENT OF LOCAL SYSTEM

Conversation was kicked-off with the goal of developing the local system. Topics included the use of an RFP or procurement/application process, how to develop the regions and who the key partners should be, what criteria do they need to meet to be eligible to participate and process of implementation.

Discussion of Key Partners

- If community-based might be ideal to have local community come together to spearhead a local entity to take the lead. Allows entities to apply but make sure all 99 counties are covered. By allowing communities to come together, the entire state would be covered.
- What do you mean by community? We should define what community is.
- There are some characteristics of community that would be important. Must have key stakeholders in the system so you might have to recruit them. It's organic. Within guiding principles, it varies.
- If key partners don't come forward, I recommend IME step-in and recruit partners to create a local SED health home.
- Recommendations include:
    - Department of Human Services (DHS)
        - Child Welfare
        - Mental Health & Disabilities
    - Iowa Medicaid Enterprise (IME)
    - Department of Public Health
    - Juvenile Justice
    - Department of Education
        - AEA
    - Primary Care Providers
        - Mental Health
        - Substance Abuse
    - Community-Based Agencies
        - Peer and family supports / peer support / youth movement
        - Vocational Rehabilitation
        - Respite
    - Higher Education
        - Board of Regents
    - Hospitals
    - Faith-based Organizations
    - Business Entities
    - Military partners
    - Foundations
    - FQHCs
    - PMICs
    - YMCA's/Fitness Clubs/Park and Rec
    - Medical Director
        - Psychologist
        - Nurses/Nurse Practitioners
        - Therapists

        - Targeted Case Management Providers
        - Adult System / Regional Coordinators (CPCs)
    - Advisory committee (all federal grants require this now)

*There needs to be further discussion about which of the above partners would be key leadership partners (Tier 1) and collaborative partners (Tier 2). Reference: Iowa System for Children DRAFT Chart.

Discussion of RFP/Procurement/Application Process

- Rather than an RPF procurement process, I recommend creating an application process but really give a region, or community, to individualize the specialized health home. Then you would be able to identify if you need one entity or multiple entities.
- Think we need standards to force providers to participate/add services.
- I recommend there are a few state parameters and then it's up to the local communities to provide the services. Definition of SOC wouldn't be the same in each region. Challenges will be there either way, but you need to put some kind of definition to the system.
- Does IME have any health homes going and how did you attract partners? We've had primary health care homes going since July 1, 2012 and we have 11 entities participating. It's taken longer than expected. They come in on their own. What we have learned is that if we leave the timeframe open ended, we'll never achieve our goal.
- Recommend defining a time schedule.
- Where is it ok to start and how long do they have to get somewhere? I recommend the timeframe be scalable.
- Recommend having technical assistance (TA) for entities that want to do participate but need help with capacity, structure, etc.
- Recommend statewide timeframe with guidance from IME on: financial, bringing small to largest counties together, etc.
- Requiring Memorandums of Understanding (MOUs) up front can kick some providers out of the mix. Maybe go slower at the start – this should create a healthier system long-term. Does leaves some counties out initially but they will need to be brought in.
- I recommend a statewide from the beginning; if not you'll perpetuate a person's zip code determining services rather than diagnosis, and I don't see how you do this in any other way than a procurement.

Group Consensus on RFP Recommendations

- The process will use an RFP procurement strategy.
- They SED health home will be community-based with one lead agency completing the RFP.
- The health home will need to provide a basis array of components with enhancements.
- The RFP will include expectations for the health home along with a review process.

Discussion on How Regions Emerge

- Should we stipulate where the regions are or let it be organic?
- We have struggled with capacity in Southern counties. What has worked as well as anything is assigning agencies to go provide services in those areas because we just don't have providers in those areas.
- One reality you'll have to look at is no one is going to be able to afford to provide services in rural areas. Need to look at financial realities of serving rural counties and how you will structure it.
- That's why you need to drag those counties that are more economically feasible to help serve those counties; tie big and small areas together.
- Creative areas will find other funding streams to pay for the services. Today, Medicaid can only pay services for Medicaid-approved children. In the future, we may speak to rethinking the spending of public agency dollars. In the beginning, the money we got is the money we got and today this does leave kids uncovered. Hopefully we can build on this and integrate not only services and service providers but funding streams.

Discussion on SED Health Home Outcomes

It was recommended that the workgroup review some current outcome tools that include standardized tools to measure family and youth outcomes, community level measures, increased capacity, tools used, etc. (SAMSHA), IDPH has one-page tool to assess how system is doing and Institute of Medicine has a list of quality and safety measures.

There was a recommendation to not limit the system to the ones we always use; rather, develop outcomes as the system develops.

Recommend there be a system collaborative goal/ process outcomes.

Education:

- Increased school attendance.
- Higher graduation rates and lower drop-out rates.
- Fewer suspensions related to behaviors.
- Ensure kids get credit for work done when in placement.
- Decrease number of days until service begins.

Financial:

- Increased expenditures in supportive type services.
- Lower level of care.
- Economic/financial costs – just not increase costs – total cost of care trend.
- True measure will be kids needing high level of service will move to lower care of services.

Juvenile Justice:

- Decrease in civil commitments.
- Reduction in number of juvenile court referrals from providers

Child Welfare:

- When kids are sent back home, is the home repaired?
- Reduction in abuse and neglect.

Child/Family:

- Decreased re-admission.
- Decrease in suicides.
- Child/family satisfaction with providers and services.
- Decreased out of home placement.
- Lower cost of psychotropic drugs for kids in state institutions.
- Quality/safety measures.

Recommendations of Provider Criteria to Apply to be a SED Health Home

- The group should work together to write the application to provide a SED Health Home but there should be one lead applicant.
- Must list who the core partners/service providers will be. The provider cannot be a single agency. Proposal must show structure of partnership with core partners in that area.
- The group should explain linkages to the adult system i.e. consider the interdisciplinary nature of these systems.
- The group should identify how they will provide equity of services and hold themselves and the partners accountable for delivering the required outcomes.

Group Consensus on Implementation Recommendations

- Recommendation that there is a scalable timeframe for the SED to get up and running.
- Recommendation that IME provides technical assistance.
- Recommendation that if an area hasn't come together, IME will become involved to help the community develop its SED health home.

## FINAL THOUGHT FROM WORKGROUP MEMBERS

- Recommend the report shows first hand how people are helping children. There is a lot of stigma and misunderstanding. The report should give examples of children/families who are currently involved in a system of care and tie their stories in with the report in the appropriate places.

## PUBLIC COMMENT

Comment: I think what we keep running up against is the fact that services are unevenly distributed and in some cases inadequate. We have to consider competitiveness among occupations, workforce, and how to build capacity. This takes time so its need to match up with financing, provider capacity and financing.

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| Comment: | The state already has a child guidance center and Community Circle of Care that are great models. It seems to me the group needs to find entities most familiar with provider and community resources in a particular geography and then talk to them. Also, the group has not talked about CMHCs and QHCs. It would be very valuable to have them put together a list of what providers they used. |
| Comment: | I liked where your outcome measurement evolved into but be careful not to make it to laborious. What you're talking about are process outcomes and those come before you get to the big ones. My program is in schools and we serve about 35-400 children/youth in schools. Please be sure they are included in a collaborative process. Also, nursing roles are changing and we need to use every level of professionalism and use it where it should be used…i.e. used appropriately. Don't limit nurses' scope of practice. |
| Comment: | You are trying to do business in a different way so there is a lot of training that needs to happen including teaching them philosophy, how to use your resources differently, etc. In Community Circle of Care (CCC) we've done a lot with families – we're never going to have enough psychologists but if you use them differently, you can free up other resources. |
| Comment: | One of the outcomes of our members is flexibility and the creation of difference types of services. There hasn't been a discussion about what services will need to be created to achieve the outcomes. I do think you need to recommend some things that you see will get this done. This will help you sell this and alleviate some concerns. |

*Next meeting: November 7, 2012 from 10:00 am to 3:00 pm at Polk County River Place, 2309 Euclid Avenue, Des Moines, IA 50310.

**There will be a workgroup conference call to review the report on Thursday, November 29 from 2:30 pm to 3:30 pm. Call in information will be emailed prior to the meeting.

**FOR MORE INFORMATION**
Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the Redesign workgroups will be posted there.